

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12392

12407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster		c. LENGTH OF STAY IN 1b 18 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster		d. STREET ADDRESS Westminster, Md. R. D. 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 2						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Calvin		First	Middle M.	Lost	4. DATE OF DEATH 11/13/59	Month 11	Day 13	Year 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7/28/1894	9. AGE (In years lost birthday) 65	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg. all kinds		11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ezra Albers				14. MOTHER'S MAIDEN NAME Rosa Mills				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. 217-12-2862		17. INFORMANT Mrs. Calvin M. Albers, Westminster, Md. R.D.2		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1</p> <p>DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</p> <p>(b) DUE TO Coronary thrombosis</p> <p>(c) DUE TO Valvular heart disease</p> <p>Coronary Occlusion</p> <p>INTERVAL BETWEEN ONSET AND DEATH sudden</p> <p>1 month</p> <p>3 years</p>								
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>none</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. 855 W. Green Westminster	(County)	(State)
<p>21. I certify that I attended the deceased from <u>Sept 15, 1959</u>, to <u>Nov 13, 1959</u>, that I last saw the deceased alive on <u>Nov 13, 1959</u>, and that death occurred at <u>10:05 A.M.</u> from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) M.D. 855 W. Green Westminster</p> <p>DATE SIGNED 11/13/59</p>								
<p>MEDICAL CERTIFICATION</p> <p>ACTUAL SIGNATURE Julius Chepko</p> <p>PHYSICIAN'S NAME (Type) Richard A. Little</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/16/59	22c. NAME OF CEMETERY OR CREMATORIAL Grave Run Cemetery			22d. LOCATION (City, town, or county) Baltimore Co., Maryland. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little			ADDRESS Littlestown, Pa.	24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

tem 20 Film 252 11-30-59 and MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 34 yrs. 5 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2533 Pennsylvania Ave.								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	Day	Year		
a. SEX Male b. COLOR OR RACE White		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH April 22, 1898				9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland				
13. FATHER'S NAME George L. Amend				14. MOTHER'S MAIDEN NAME Mary Cecilia Gilmore				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES <small>(Yes, no, or unknown)</small>		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records <small>Address</small>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: <small>IMMEDIATE CAUSE (a)</small> Hypostatic bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Days <small>904.7</small>												
<small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> Fracture, neck right femur 18 days <small>(b)</small>												
<small>DUE TO</small> <small>(c)</small>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy with mental deficiency.												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <small>CAUSE OF DEATH.</small>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor										19. WAS AUTOPSY PERFORMED? <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>
20c. TIME OF INJURY Month, Day, Year <small>Hour</small> o. m. <small>p. m.</small> 11/5/59		20d. INJURY OCCURRED <small>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></small>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Sykesville <small>(County)</small> Carroll <small>(State)</small> Md.						
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <small>Actual Signature</small> James T. Marsh												
<small>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></small> <small>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></small> <small>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></small>												DATE SIGNED 11/23/59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORIAL St Peters		22d. LOCATION (City, town, or county) Balto. <small>(State)</small> Md.						
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Rose		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
<small>V.S. A15ME(5)</small> <small>SM 9/55</small>				<small>DATE</small> NOV 27 '59								

MASSACHUSETTS STATE BANKNOTE DIVISION—SERIAL NUMBER 10
MEDICAL EXAMINER CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

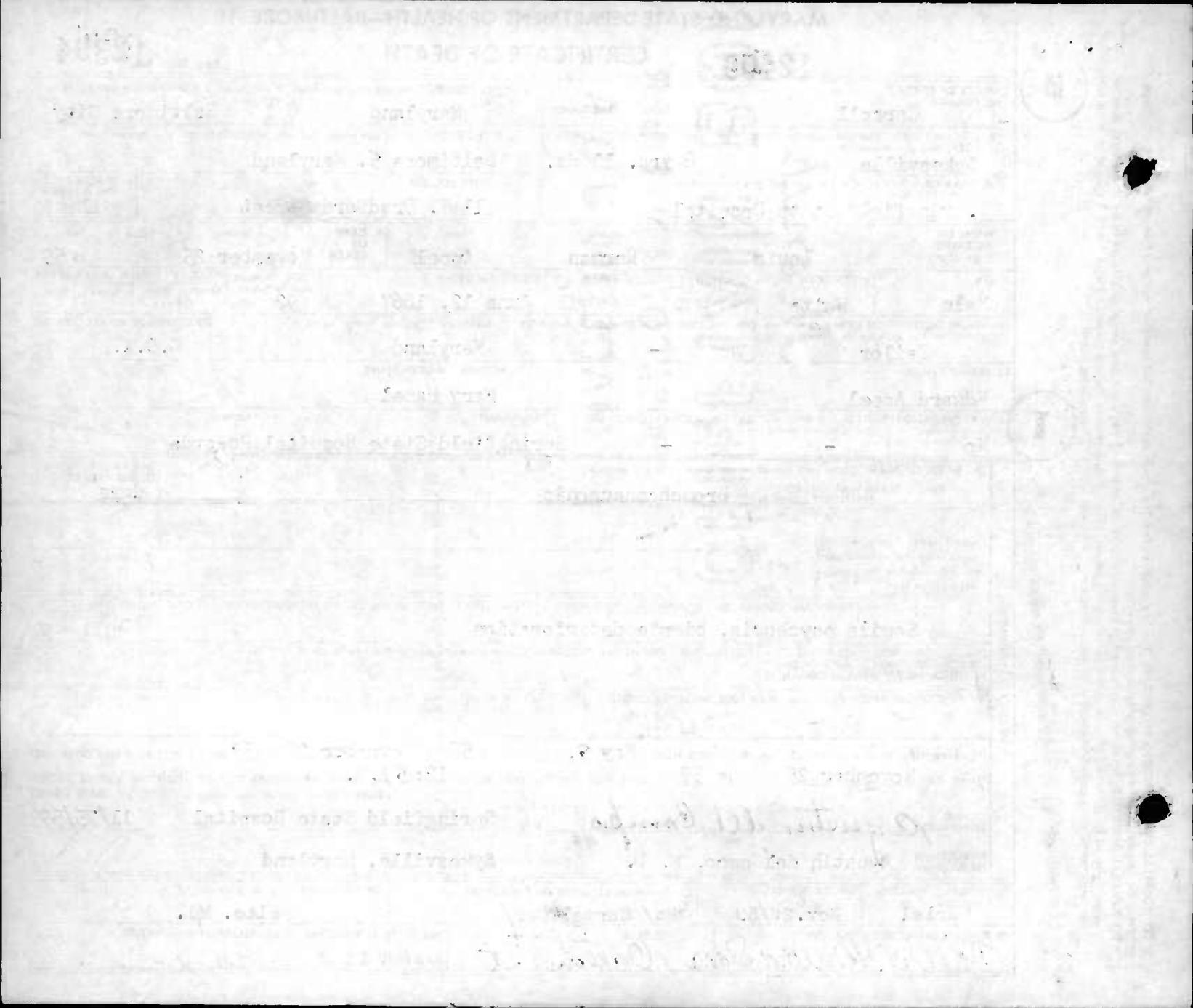
12394

12409

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 8 yrs. 11 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Louis	Middle Herman	Last Appel
4. DATE OF DEATH	Month November	Day 25	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1867
9. AGE (In years last birthday) 92 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Edward Appel		
14. MOTHER'S MAIDEN NAME Mary Hamel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -		INFORMANT Springfield State Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis, simple deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 9, 1958 , to November 25, 1959 , that I last saw the deceased alive on November 25, 1959 , and that death occurred at 12:45 A.M. From the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustini del Campo</i>			ADDRESS (Street, city or town, state) Sykesville, Maryland
PHYSICIAN'S NAME (Type) Agustini del Campo, M. D.			DATE SIGNED 11/25/59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 28/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip Henry Sons Orleans St</i>	ADDRESS 2024	24a. REC'D BY REGISTRAR DATE NOV 30 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please report to carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12410 CERTIFICATE OF DEATH 12395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lykensville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lykensville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <i>Louis Lee Armsworthy</i>			First	Middle	Last
4. DATE OF DEATH <i>Nov. 24</i>		Month	Day	Year <i>1959</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>Nov. 30 1882</i>	9. AGE (In years lost birthday) <i>76</i> yrs.	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Springfield Hospital</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>6-12-3456</i>		17. INFORMANT Address <i>Mrs. Mary A. Armsworthy - Wife</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hours.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Generalized arteriosclerosis</i> years. (c) DUE TO <i>Hypertension</i> years.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Lykensville</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>11. 24. 1959</i> to <i>11. 24. 1959</i> , that I last saw the deceased alive on <i>11. 24. 1959</i> , and that death occurred at <i>6:35 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>37 Central Ave. Sykesville Md.</i> DATE SIGNED					
ACTUAL SIGNATURE <i>Sani Okutman</i>		PHYSICIAN'S NAME (Type) <i>A. Sani Okutman</i>			
220. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-27-59</i>		22c. NAME OF CEMETERY OR Crematory <i>Springfield</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Knapp</i>		ADDRESS <i>1000 W. Main St. Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

WISCONSIN STATE GOVERNMENT OF HAZEL - BIRKINBROOK 18

SUPERIOR CERTIFICATE OF DEATH

1900-1901

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12396

12411

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Carroll Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Uniontown

c. LENGTH OF STAY IN 1b

3 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Md.

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Uniontown, Md.

d. STREET ADDRESS

Uniontown Road

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
HelenMiddle
LouiseLast
Berkemeier4. DATE
OF
DEATH
November 29, 1959

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

February 27, 1880

9. AGE (In years
lost birthday)79
yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Schlegel

14. MOTHER'S MAIDEN NAME

Unknown

Address
Uniontown, Md.15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

No None

16. SOCIAL SECURITY NO.

Unknown

INFORMANT

Mr. Calvin C. Berkemeier, Uniontown Rd.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Hypertensive Cardio-Vascular Disease; years.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 4/1/59, 19, to 11/29/59, 19, that I last saw the deceased
alive on 11/23/59, 19, and that death occurred at 6:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M. E. Robertson

M.D.

New Windsor, Md. 11/29/59

PHYSICIAN'S
NAME (Type)

M. E. Robertson, M.D.

New Windsor, Md.

22a. BURIAL, CREMATION, REMOVAL
Burial Dec. 2, 1959

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Druid Ridge Cemetery

22d. LOCATION (City, town, or county)

(State)

Pikesville 8, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Frank H. Lewis

ADDRESS

Pikesville

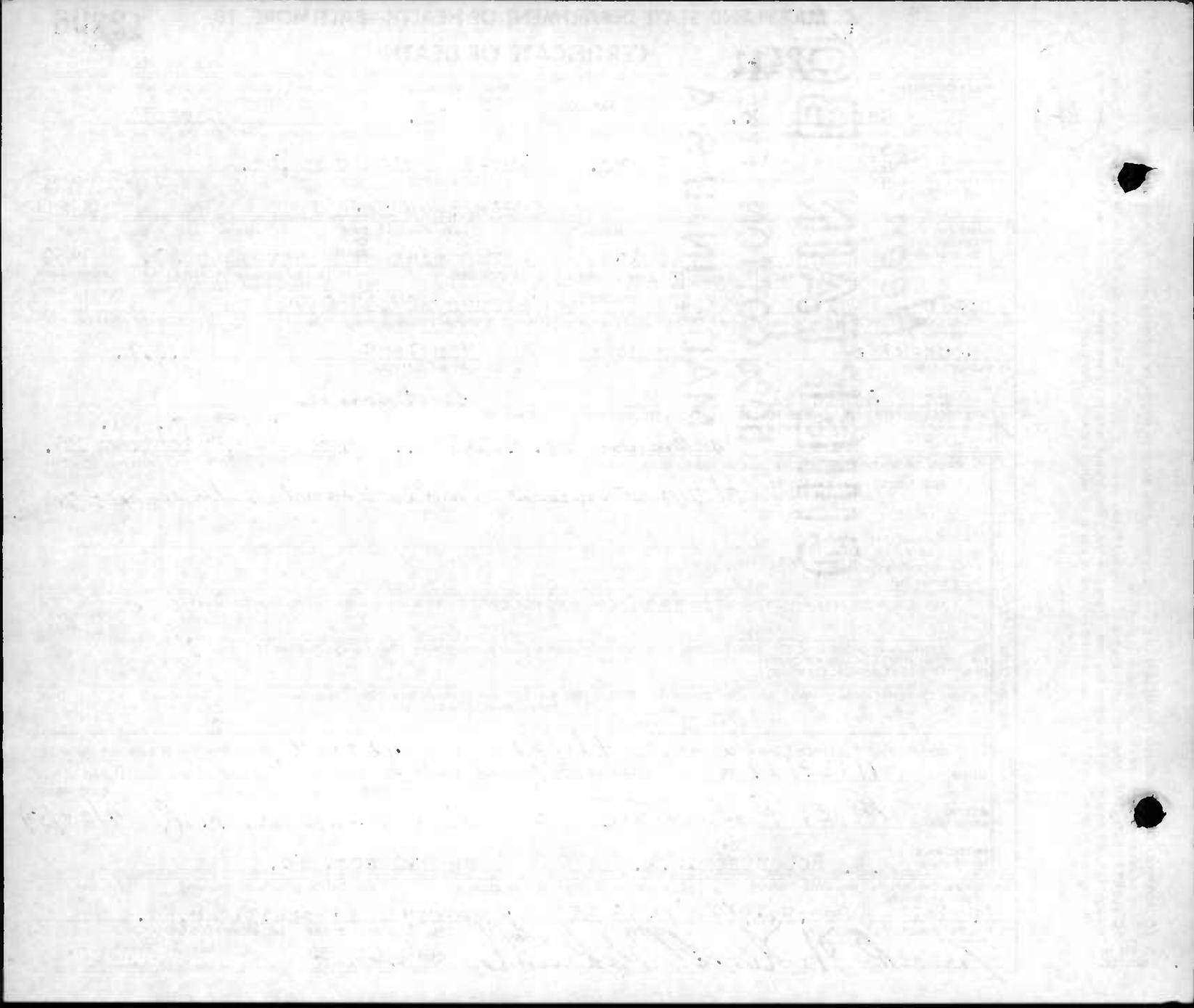
24a. REC'D BY REGISTRAR

DATE DEC 3 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page
may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3809 Oxford Ave., Apt. D.	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle (Dortch)	Last Borch
4. DATE OF DEATH 11	Month 7	Day 19	Year 59
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/9/18
9. AGE (In years last birthday) 41 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Max Dorch		
14. MOTHER'S MAIDEN NAME Jenny Tublan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 219-38-3018		INFORMANT Records Springfield Hosp. Sykesville, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH days	
DUE TO 591X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Uremia due to subacute glomerulonephritis		days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Primary behavior disorder; conduct disturbance.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		(County) (State) Maryland	
21. I certify that I attended the deceased from 11/2/59 , 19, to 11/7/59 , 19, that I last saw the deceased alive on 11/7/59 , 19, and that death occurred at 3:55 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francesco Magro</i>		ADDRESS (Street, city or town, state) Springfield Hospital, Sykesville, Md.	
PHYSICIAN'S NAME (Type) Francesco Magro, M.D.		DATE SIGNED 11/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 9-1959	22c. NAME OF CEMETERY OR CREMATORIAL Mt Carmel	22d. LOCATION (City, town, or county) Baltimore (State) Mary.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>	ADDRESS 2100 Eastern Place.	24a. REC'D BY REGISTRAR NOV 10 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED ON 10/26/1988

1740 TO 1840 HRS

100

100

100

Frank and I went to

the building corp

on 10th and 18th street

100

100

Frank and I went to

the building corp

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12413

CERTIFICATE OF DEATH

Reg. Dist. No.

12398

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 33 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
515		d. STREET ADDRESS 4 Chestnut Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nellie	Middle N.	Last Boughner
4. DATE OF DEATH	Month November	Day 2,	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 16, 1881
9. AGE (In years last birthday) 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Boughner		14. MOTHER'S MAIDEN NAME Mary N. Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. - - -	INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced bilateral pulmonary tuberculosis</u> INTERVAL BETWEEN ONSET AND DEATH Years DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 7, 1955</u> , to <u>November 2, 1959</u> , that I last saw the deceased alive on <u>November 2, 1959</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>Springfield State Hospital</u> DATE SIGNED <u>11/2/59</u>			
ACTUAL SIGNATURE <i>Agustin del Campo</i>	PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u> Sykesville, Maryland		
22a. BURIAL, CREMATION, b. (Specify) <u>burial</u>	22b. DATE THEREOF <u>11/5/59</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St., N.W.</u>		ADDRESS <u>Wash. D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12414

CERTIFICATE OF DEATH

Reg. Dist. No.

12399

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 3 yrs. 7 mths.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda GLEN ECHO HEIGHTS. 15 X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 6103 WALHONDING ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Celestenia	Middle Serena	Last Brady
4. DATE OF DEATH	Month Nov. 28	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-72
9. AGE (In years last birthday) 87	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. SEX Female	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME Martha Crippen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	INFORMANT Mrs. Florence Benson	Address 6103 Walhonding Rd. Glen Echo Heights, Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause lost.</u> (b) Broncho-pneumonia DUE TO (c) Arterio Sclerotic Heart Disease DUE TO (d) General Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/12/5 , 19 59 , to 11/12/8 , 19 59 , that I last saw the deceased alive on 11/12/8 , 19 59 , and that death occurred at 12:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hosp.			
ACTUAL SIGNATURE <i>Francesco Magro</i>	M.D.	DATE SIGNED 12/1/59	
PHYSICIAN'S NAME (Type) Francesco Magro			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/2/59	22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. FUMPHREY INC.	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE DEC 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12415 CERTIFICATE OF DEATH 12400
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>17 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>31 Central Ave.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>	
3. NAME OF DECEASED (Type or print) <i>Minnie</i>		d. STREET ADDRESS <i>31 Central Ave.</i>	
4. DATE OF DEATH <i>11 13 1959</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 28 1872</i>
9. AGE (In years lost birthday) <i>87 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Hobbs.</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elan Doyle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Oscar L. Heathins, Sykesville</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		Cerebral Hemorrhage	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO		Hypertension, Arteriosclerosis 4 months	
(c) DUE TO		Cardiovascular disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>7-9</i> , 19 <i>59</i> , to <i>11-13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-13</i> , 19 <i>59</i> , and that death occurred at <i>6004</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sani Okutman</i>		ADDRESS (Street, city or town, state) <i>37 Central Ave, Sykesville Md. Nov 14 59</i>	
PHYSICIAN'S NAME (Type) <i>Sani A. Okutman</i>		DATE SIGNED <i>Sykesville Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-15-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Sykesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Haight, Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Haight</i>	

CERTIFICATE OF DEATH

DEATH CERTIFICATE

REGISTRATION

STATE

STATE

DEPARTMENT OF HEALTH - STATEWIDE



REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12401

Reg. Dist. No.

12415

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 yrs. 8 mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone		d. STREET ADDRESS None		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Helena		First	Middle	Last	4. DATE OF DEATH November 19, 1959	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1921	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Minnie Stickley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		Bilateral aspiration bronchopneumonia					24 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) (Final diagnosis to be determined by toxicological studies.)						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Psychoneurotic disorder, anxiety reaction.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/20/59			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORIUM Freedom		22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Franklin H. Hough Sykesville, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 25 '59	24b. REGISTRAR'S SIGNATURE E. Clegg & Knapp			
VS. A15ME(5) 5M 9/55								

Phone st and Expire.

No report 2/2/60
as.

109 E. Main St
Weston, W. Va.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12417 12402
CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marietta</i> 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <i>John William Burke</i>			4. DATE OF DEATH <i>November 8 1959</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>August 31, 1901</i>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto mechanic</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		
11. BIRTHPLACE (State or foreign country) <i>Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Burke</i>			14. MOTHER'S MAIDEN NAME <i>Annie C. Cutsail</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>578-09-1760</i> 17. INFORMANT <i>William C. Burke</i> Address <i>Sykesville, Md. Box 83</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary thrombosis, arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>1958</i>					
Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) DUE TO <i>lung disease, arteriosclerosis generalized to</i> (c) <i>8 Nov 59</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Nov 19 1959</i> to <i>Nov 19 1959</i> that I last saw the deceased alive on <i>8 Nov 1959</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.			ADDRESS (Street, city or town, state) <i>Howard, Md</i> DATE SIGNED <i>11-8-59</i>		
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>			22c. NAME OF CEMETERY OR CREMATORIAL <i>Providence Cemetery</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 11, 1959</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick County, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>			24a. REC'D BY REGISTRAR <i>Nov 12 '59</i> DATE		
			24b. REGISTRAR'S SIGNATURE <i>Howard E. Hall</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12418

CERTIFICATE OF DEATH

12403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Flag Marsh Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Mt. Airy	
3. NAME OF DECEASED (Type or print) ELSIE		First THOMAS	Middle DAVIS
4. DATE OF DEATH Nov. 6, 1959		Last DAVIS	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 12-17-1894
8. AGE (In years from birth to death) 64 yrs.		9. IF UNDER 1 YEAR Months 6	10. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John E. Davis	
14. MOTHER'S MAIDEN NAME Linda E. Hatfield		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. August E. Davis, same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X		19. INTERVAL BETWEEN ONSET AND DEATH 2 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		Cancerous of stomach and General Metastasis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 14, 1959, to Nov 6, 1959 , that I last saw the deceased alive on Nov 5, 1959 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. M. Van Poole		ADDRESS (Street, city or town, state) Mt. Airy Md	
PHYSICIAN'S NAME (Type) C. M. Van Poole		DATE SIGNED 11-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-9-1959	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive
22d. LOCATION (City, town, or county) Carroll Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		24a. REC'D BY REGISTRAR DATE NOV 10 '59	24b. REGISTRAR'S SIGNATURE Calvin S. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12404

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12419

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION En route to Henryton State Hosp.		d. STREET ADDRESS 517 E. 23rd Street	
3. NAME OF DECEASED (Type or print) Benjamin Hill		4. DATE OF DEATH Dudley	Month Nov. Day 24 Year 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12-23-1898	9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Raleigh, N. C.
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Enid Dudley - Same as patient
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Diabetic Mellitus DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 18 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>James J. Marsh, Deputy Med Examiner</i>		DATE SIGNED 11/24/59	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) burial		22b. DATE THEREOF 11/28/59	22c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cemetery
22d. LOCATION (City, town, or county) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elroy O'Wilson - 1000 Broadway</i>		24a. ADDRESS	24b. REC'D BY REGISTRAR DATE NOV 27 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12420

CERTIFICATE OF DEATH

12405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 30 yrs. 1 mo. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Mary		First Winkler	Middle Emrine
4. DATE OF DEATH November		Month 20	Day 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 29, 1892		9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alvin Winkler		14. MOTHER'S MAIDEN NAME Walburga Tuchholz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	INFORMANT Springfield Hospital Records
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH Years	
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy with mental deficiency.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetes Mellitus.	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955 , to November 20, 1959 that I last saw the deceased alive on November 19, 1959 , and that death occurred at 12:15 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Agustini del Campo</i>		M.D. Springfield State Hospital 11/20/59	
PHYSICIAN'S NAME (Type) Agustini del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORIAL Holy REDEEMER
22d. LOCATION (City, town, or county) BALTIMORE, Md			
23. FUNERAL DIRECTOR'S SIGNATURE GEO. L. Schwab FUNERAL Home ADDRESS Francis W. Miller & Co. Frederick Ave. Baltimore, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12406

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 74 Ralph St		e. STREET ADDRESS 74 Ralph St	
3. NAME OF DECEASED (Type or print) CHARLES		First L	Middle ENDERS
4. DATE OF DEATH Nov 24 1959	Month Nov	Day 24	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1885
9. AGE (In years from birth) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. IF UNDER 24 HRS. Min. 0	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret'd Machinist		
10b. KIND OF BUSINESS OR INDUSTRY Franklin Balmar Corporation		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 214-03-2754		17. INFORMANT Marie J. Enders, Westminster, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO As. C. V. Disease (c)		19. INTERVAL BETWEEN ONSET AND DEATH year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , to 11-24-59 , that I last saw the deceased alive on 11-2-59 , 1959, and that death occurred at 638 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md			
ACTUAL SIGNATURE James J. Marsh		DATE SIGNED 11-24-59	
PHYSICIAN'S NAME (Type) JAMES T. MARSH		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 11-27-59		22c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial Garden	
22d. LOCATION (City, town, or county) Carroll County, Md		23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DATE NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Cause of death	
John Doe		Diseased	
Age		Place of death	
65 years		Baltimore, MD	
Sex		Time of death	
Male		10:00 AM	
Race		Date of death	
White		1965	
Occupation		Time of issue	
Retired		1965	
Residence		Place of issue	
Baltimore, MD		Baltimore, MD	
Name and address of physician		Name and address of coroner	
John Doe, 123 Main Street, Baltimore, MD		John Doe, 123 Main Street, Baltimore, MD	
Name and address of hospital		Name and address of funeral home	
John Doe Hospital, Baltimore, MD		John Doe Funeral Home, Baltimore, MD	
Name and address of informant		Signature of physician	
John Doe, 123 Main Street, Baltimore, MD		John Doe, M.D.	
Signature of coroner		Signature of funeral director	
John Doe, M.D.		John Doe, Funeral Director	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12421

CERTIFICATE OF DEATH

Reg. Dist. No.

12467

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
(Rural) Sykesville		c. LENGTH OF STAY IN 1b 4mo 11day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13, 3VO1-4					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3531 Lyndale Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First H enry	Middle Joseph	Last Fleischman	4. DATE OF DEATH 6/14/94	Month 11	Day 4	Year 19 59		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 6/14/94	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Fleischman		14. MOTHER'S MAIDEN NAME Elizabeth--- Geiss							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records Springfield State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 023X DUE TO Cerebral embolism more than hours									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Syphilitic Aortitis more than 1 yr.									
(c) DUE TO Hypertensive cardiovascular disease more than 5 years.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic with psychotic reaction.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <u>October 20 19 59</u> to <u>Nov. 4 19 59</u> , that I last saw the deceased alive on <u>Nov. 4 19 59</u> , and that death occurred at <u>12:25 p.m.</u> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Walter Knopp, M.D. 11-4-59 DATE SIGNED	
ACTUAL SIGNATURE Walter Knopp, M.D.									
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.									
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 11/7/59		22c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane		ADDRESS		24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

WORLD WAR II STAGE OF SERVICE OF HENRY S. GALLAGHER

CERTIFICATE OF DEATH

1941

NAME



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12422 CERTIFICATE OF DEATH

Reg. Dist. No. 12408

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Manchester</i>		c. LENGTH OF STAY IN 1b <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>LEVI</i>	Middle <i>J</i> Last <i>Forrester</i>
4. DATE OF DEATH		Month <i>Nov</i>	Day <i>13</i>
		Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-16-1889</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>78</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during/most of working life, even if retired) <i>Retired operator Balti Transit</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Transit</i>	
10c. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>W. W. A.</i>	
13. FATHER'S NAME <i>Philmore Forrester</i>		14. MOTHER'S MAIDEN NAME <i>Arabella Headley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>213-10-1488</i>	
17. INFORMANT <i>Jackson Forrester-Manchester Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Anterior descending Heart Disease</i> DUE TO (c)		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Manchester</i> (County) <i>MD</i> (State) <i>MD</i>
21. I certify that I attended the deceased from <i>June</i> , 19 <i>59</i> , to <i>Nov 13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov 13</i> , 19 <i>59</i> , and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H Foard</i>		ADDRESS (Street, city or town, state) <i>25 N Main St Manchester, Md</i> DATE SIGNED <i>11-13-59</i>	
PHYSICIAN'S NAME (Type) <i>W H Foard, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-16-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baptist Cemetery</i>
22d. LOCATION (City, town, or county) <i>Manchester</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw S. Tipton Hempstead Md</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>VS A 15 (4)</i> DATE NOV 17 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

SCOTTISH LANDSCAPE STATION
HADDO BRACHFIELD SS121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12423

CERTIFICATE OF DEATH

12409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural--Mt. Airy	
3. NAME OF DECEASED (Type or print) WILLIAM J. FRANKLIN		d. STREET ADDRESS Rt 27	
4. DATE OF DEATH NOV. 9, 1959		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Nathan Franklin		14. MOTHER'S MAIDEN NAME Martha E. ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Olin Franklin, same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH yrs Hyperension, Arterio Sclerosis yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 23, 1959</u> to <u>Nov 9, 1959</u> that I last saw the deceased alive on <u>Oct 23, 1959</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED M.D.	
ACTUAL SIGNATURE <i>C. M. Waltz</i>	PHYSICIAN'S NAME (Type) <i>C. M. Waltz, Winfield, Md.</i>	22d. LOCATION (City, town, or county) Carroll Co., Maryland (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-12-1959	22c. NAME OF CEMETERY OR CREMATORIAL Taylorsville	24a. REC'D BY REGISTRAR NOV 13 '59
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

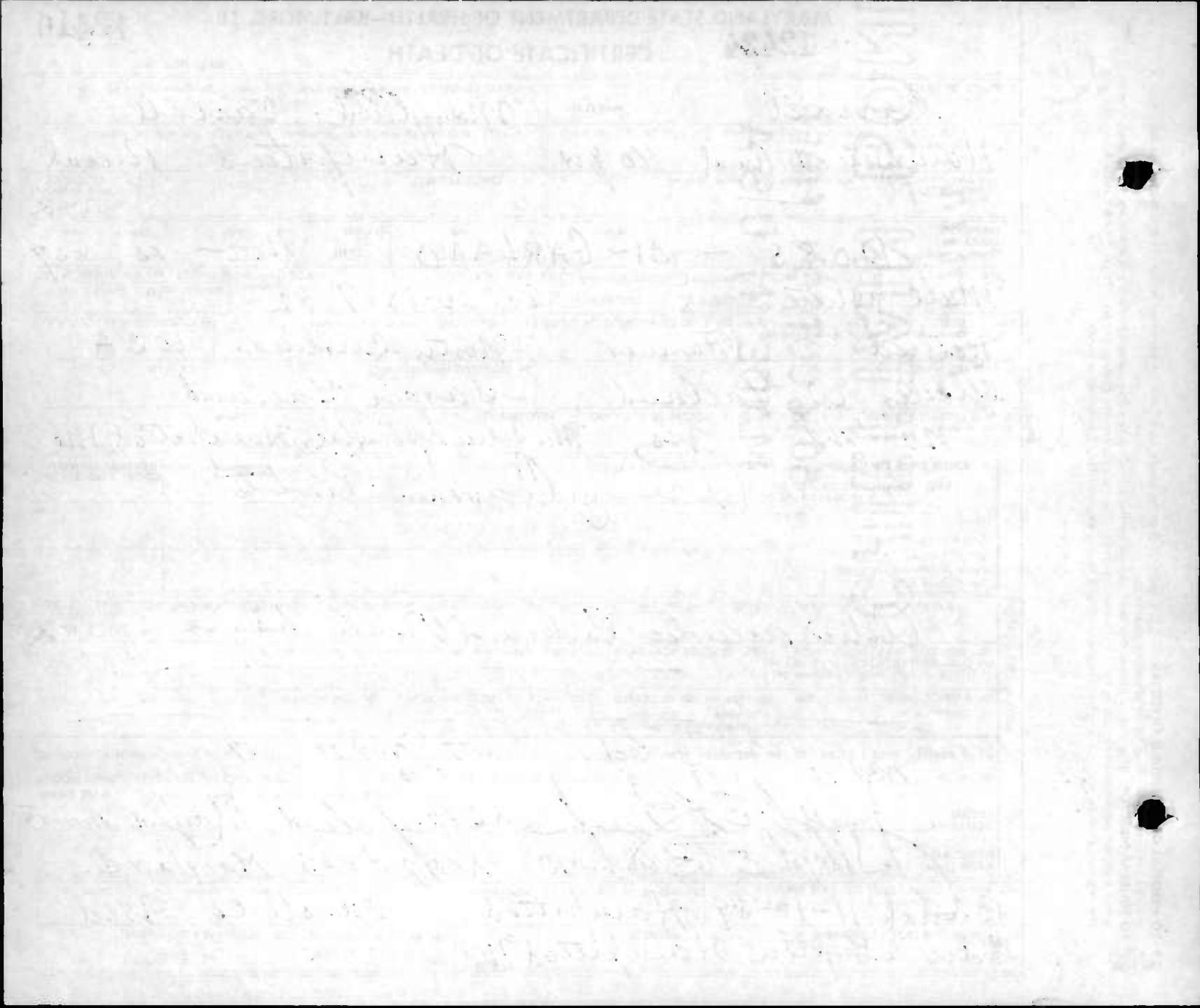
12424

CERTIFICATE OF DEATH

12410

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Rural</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Rural</i>	
3. NAME OF DECEASED (Type or print) <i>Doss — M — GARLAND</i>		d. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 30-1877</i>	
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles W Garland</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Garland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>710</i>	
17. INFORMANT <i>Mrs John Sprinkle. Hampstead Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177x</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Ciliis sclerotic Caudate and Vasular Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>—</i>	
20f. (City or town) <i>—</i>		(County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>Oct 1</i> , 19 <i>57</i> , to <i>Nov 10</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Nov 10</i> , 19 <i>57</i> , and that death occurred at <i>5130</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Hampstead Maryland</i>	
ACTUAL SIGNATURE <i>Joseph E. Bush, M.D.</i>		DATE SIGNED <i>11-11-57</i>	
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-13-59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Hampstead</i>		22d. LOCATION (City, town, or county) <i>Carroll Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar G. Gipson Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Evans</i>	

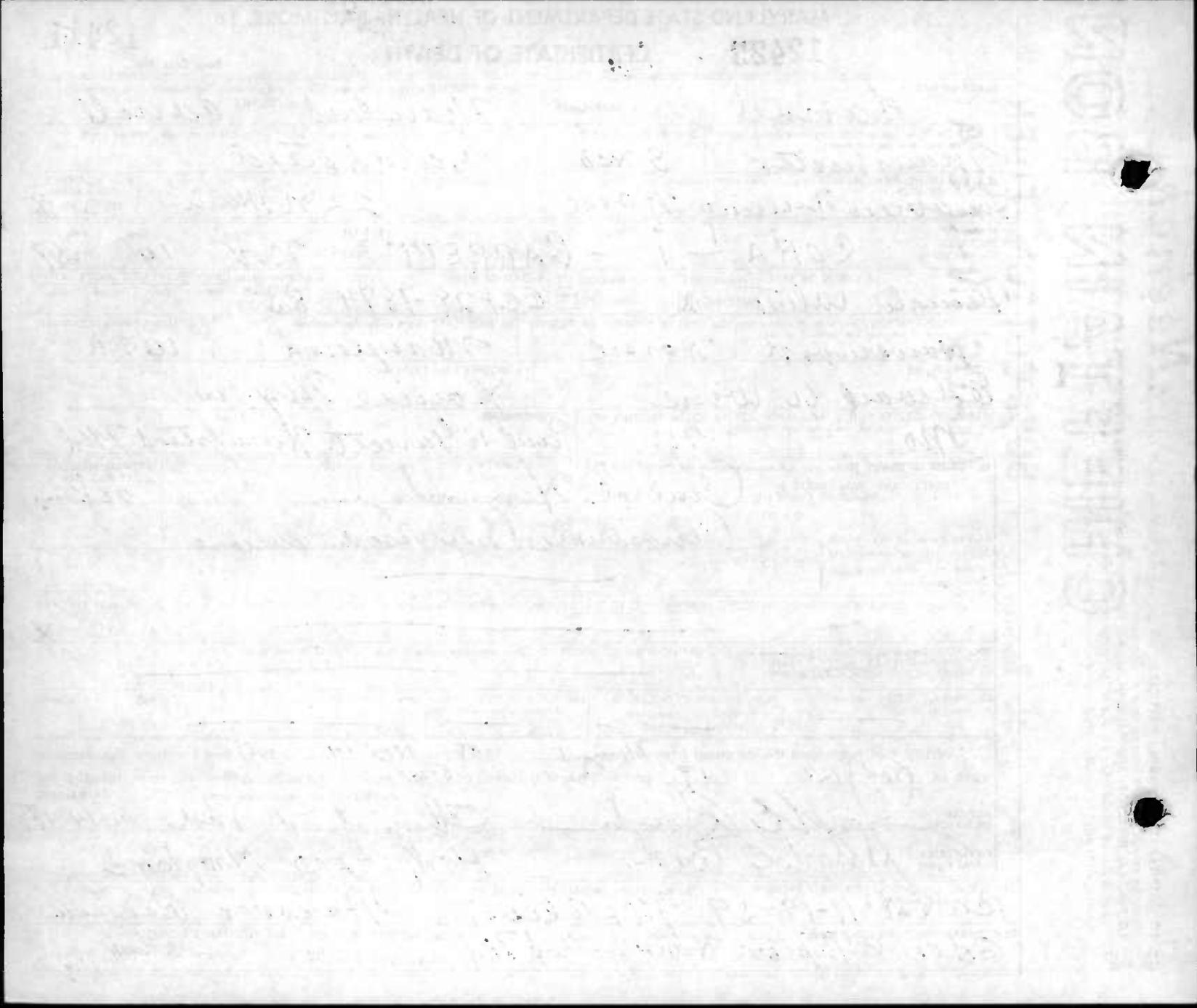


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12425 CERTIFICATE OF DEATH

12411
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE								
Baltimore Maryland		b. COUNTY								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 8 mos								
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 22 N Main								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Longview Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle							
CORA		i	-GARRETT	Last	4. DATE OF DEATH	Month	Day	Year		
S. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Oct 28-1874			Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Housework		Home		Maryland		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Edward W. Wise		Louise Myers								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address				
No		No		Paul R. Garrett, Hampstead Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
422.1 Cerebral Hemorrhage 72 hours										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.										
DUE TO (b) Alcoholic Cardio-Vascular Disease (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>February 1, 1957</u> , to <u>Nov 14, 1957</u> , that I last saw the deceased alive on <u>Nov 13, 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.										
ADDRESS (Street, city or town, state)										
DATE SIGNED										
ACTUAL SIGNATURE <u>Jay E. Bush M.D.</u> ADDRESS <u>Hampstead Md</u> DATE SIGNED <u>11-14-57</u>										
PHYSICIAN'S NAME (Type)		HAMPSTEAD Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)		
Burial		11-17-59		McAlvet		Hampstead		Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
Edie E. Tipton Hampstead Md				NOV 17 '59		Arthur & Kimes				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12426 CERTIFICATE OF DEATH

Reg. Dist. No. 12412

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Fredrick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson, Maryland		d. STREET ADDRESS 10X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Richard		First	Middle Nevin	Last Gordon	4. DATE OF DEATH 11	Month 11	Day 14	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4/11/74	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months 85	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sam Gordon			14. MOTHER'S MAIDEN NAME Lydia Ruse					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-24-1484		17. INFORMANT Springfield State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 434.1 INTERVAL BETWEEN ONSET AND DEATH days Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congestive Heart Failure days (c) CBS assoc. with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8/1/59 , 19, to 11/14/59 , 19, that I last saw the deceased alive on 11/14/59 , 19, and that death occurred at 6:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Francesco Magro, M.D. DATE SIGNED 14 Nov 1959								
ACTUAL SIGNATURE <i>Francesco Magro</i>		22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-17-59 22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial Park 22d. LOCATION (City, town, or county) Frederick, Maryland (State)						
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 16 '59 24b. REGISTRAR'S SIGNATURE Antoin & Frans						

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12427

CERTIFICATE OF DEATH

Reg. Dist. No.

12413

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b RURAL and give nearest town Finksburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Murray Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Chloe		Middle C.				
Last Grafton		4. DATE OF DEATH Nov.	Month 25	Day 19	Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1871	9. AGE (In years lost birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Forest Hill, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Kean		14. MOTHER'S MAIDEN NAME Street DeVoe		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Harry E. Ward		Finksburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 15 mins.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Arteriosclerotic Cardio Vascular Disease		years		
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____ June _____, 1957, to Nov. 25, 1959, that I last saw the deceased alive on Nov. 18, 1959, and that death occurred at 7 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street		DATE SIGNED 11-27-59		
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.				Reisterstown, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 28, 59	22c. NAME OF CEMETERY OR CREMATORIUM Old Brick Church Cem.	22d. LOCATION (City, town, or county) Jarrettsville, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12428 CERTIFICATE OF DEATH

12414
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll County									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS									
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Lillian Middle M. Last Gutridge		4. DATE OF DEATH Month November Day 5 Year 1959									
5. SEX FEMALE WHITE		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1926		9. AGE (In years last birthday) yrs. 32		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry E. Kohls		14. MOTHER'S MAIDEN NAME Catherine L. Prietz									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Henry E. Kohls		Address Hampstead, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 416X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Rheumatic Heart Disease (c)		Coronary Insufficiency				INTERVAL BETWEEN ONSET AND DEATH 5 Minutes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Angina Pectoris 1 year						2 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and the death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE M. C. Porterfield										ADDRESS (Street, city or town, state) Hampstead, Md.	
PHYSICIAN'S NAME (Type) M. C. Porterfield										DATE SIGNED 11/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		22d. LOCATION (City, town, or county) 3310 Taylor Ave		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12405

CERTIFICATE OF DEATH

Reg. Dist. No.

12415

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>49 yrs.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>60 East Main St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>HENRY HIRSH HARBAUGH, II</i>		First <i>HENRY</i>	Middle <i>HARBAUGH, II</i>			
4. DATE OF DEATH <i>November 18 1959</i>		Last <i>II</i>	Month <i>November</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15 1910</i>			
9. AGE (In years lost birthday) yrs. <i>49</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>			
13. FATHER'S NAME <i>Henry H. Harbaugh, II</i>	14. MOTHER'S MAIDEN NAME <i>Sally Flesley</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
16. SOCIAL SECURITY NO. <i>213-69-9156</i>	17. INFORMANT <i>Ezra W. Harbaugh, Westminster, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. INTERVAL BETWEEN ONSET AND DEATH <i>35 min.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour p. m. 19	Month o. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1058 Main St.</i>	20f. (City or town) <i>Westminster</i>	(County) <i>Carroll</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>11/18</i> , 19 <i>59</i> , to <i>11/18</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/18</i> , 19 <i>59</i> , and that death occurred at <i>1058 Main St.</i> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>James T. Marsh</i> M.D. ADDRESS (Street, city or town, state) <i>1058 Main St.</i> DATE SIGNED <i>11/19/59</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/21/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Frederick Cemetery, Rural, Westminster, Md.</i>	22d. LOCATION (City, town, or county) (State) <i>Westminster, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr. Westminster, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12429

CERTIFICATE OF DEATH

12416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clarksville</i>		c. LENGTH OF STAY IN 1b <i>50 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Sykesville</i>		d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CARRIE</i>		First <i>ESTELLE</i>	Middle <i>HAWKINS</i>	Last	4. DATE OF DEATH <i>Nov. 13 1959</i>	Month <i>Nov.</i>	Day <i>13</i>	Year <i>1959</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 6, 1884</i>	9. AGE (In years lost birthday) <i>75 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Jesse P. Brandenburg</i>		14. MOTHER'S MAIDEN NAME <i>Florence Carroll</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Oscar Hawkins - Sykesville, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i> DUE TO <i>Generalized, arteriosclerotic heart disease,</i> <i>(c)</i> <i>hypertension</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1955</i> <i>13 Nov</i> <i>1959</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1</i>		20f. (City or town) <i>Sykesville</i>		(County) <i>Howard</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>1955</i> , 19 <i>57</i> , to <i>13 Nov.</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>13 Nov.</i> , 19 <i>59</i> , and that death occurred at <i>3:00 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i>		DATE SIGNED <i>13 Nov 59</i>	
ACTUAL SIGNATURE <i>Howard E. Hall</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i>						SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bury</i>		22b. DATE THEREOF <i>11-16-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Sykesville, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i>		ADDRESS <i>Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Haight</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12417

12430

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN 1b <i>25 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
3. NAME OF DECEASED (Type or print) <i>BIRDIE</i>		First <i>B</i>	Middle <i>-</i>
4. DATE OF DEATH <i>NOV 12 1959</i>		Last <i>H</i>	Month <i>NOV</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>A</i>
8. DATE OF BIRTH <i>3-1-1889</i>		9. AGE (In years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>
11. CITIZEN OF WHAT COUNTRY? <i>USA</i>		12. MOTHER'S MAIDEN NAME <i>Mary E. Lunders.</i>	
13. FATHER'S NAME <i>George W Hoffacker</i>		14. INFORMANT <i>Mrs Harvey Rhodes Westminister Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>315-07-1613</i>	17. ADDRESS <i>Westminister Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Coronary Thrombosis</i>		Arterosclerotic Heart Disease <i>5 yr</i>	
DUE TO <i></i>		(c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Jan 19 59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>59</i> , to <i>Nov 12</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Oct</i> , 19 <i>59</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>25 N Main St</i>	
ACTUAL SIGNATURE <i>W H Foard</i>		DATE SIGNED <i>11/13/59</i>	
PHYSICIAN'S NAME (Type) <i>W H Foard M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>11-15-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Manchester</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar S. Lipton Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 17 '59</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12431

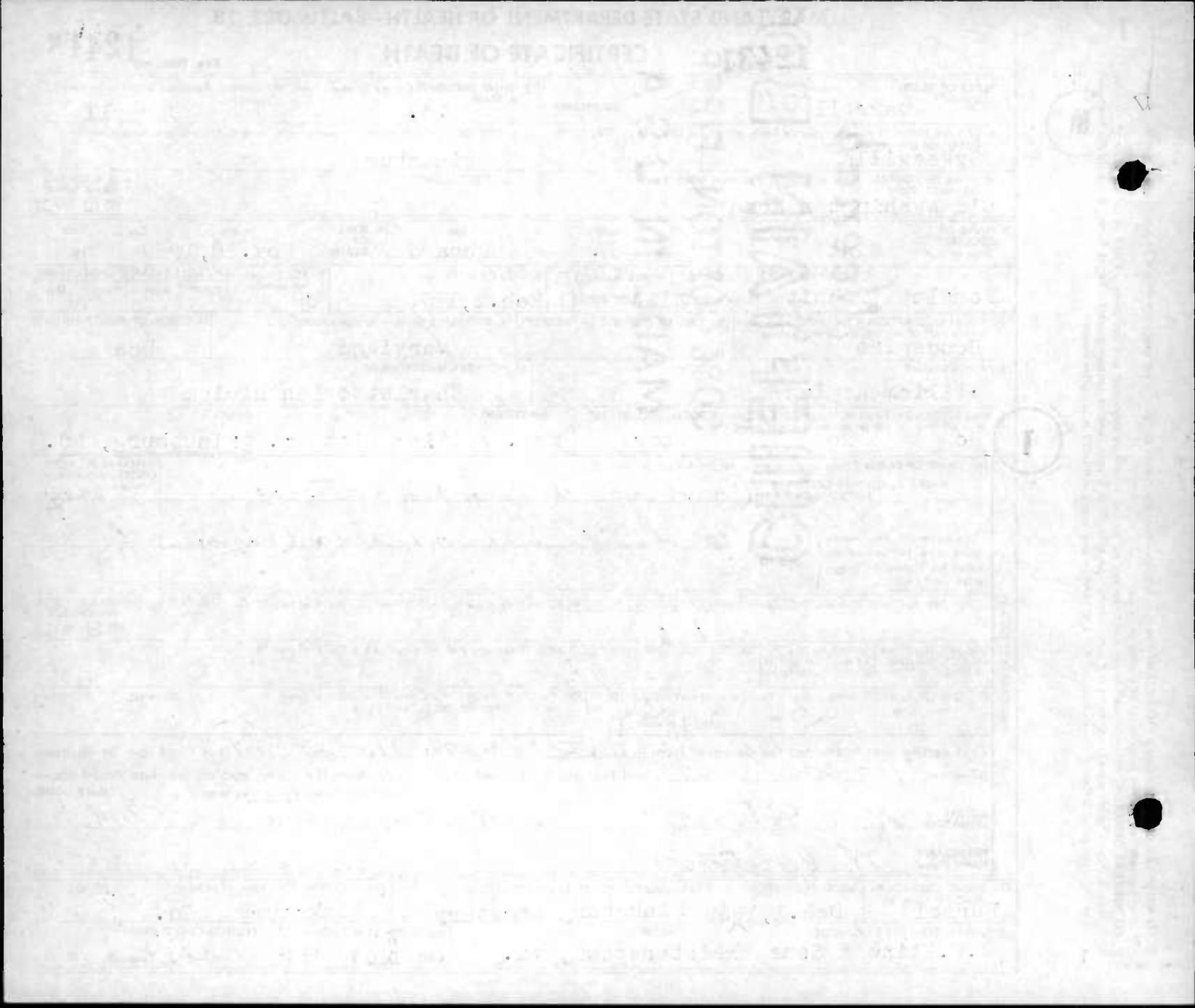
CERTIFICATE OF DEATH

Reg. Dist. No.

12418

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Washington Road		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mina	Middle L.	Last Hubbard
4. DATE OF DEATH	Month Nov. 28, 1959	Day 19	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1870
9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months /	11. IF UNDER 24 HRS. Days /	12. IF UNDER 24 HRS. Hours /
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Asplen		14. MOTHER'S MAIDEN NAME Charlotte Lenthicium	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	INFORMANT Mrs. William Gist Jr. Finksburg, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Cardiac decompensation</i> INTERVAL BETWEEN ONSET AND DEATH 5 day 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b): <i>Cardiovascular disease (chronic)</i> DUE TO (c): <i>Chronic</i> DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>No</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No</i>		
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>No</i>	20f. (City or town) <i>No</i>
21. I certify that I attended the deceased from <i>Oct. 1, 1959</i> to <i>11-28, 1959</i> , that I last saw the deceased alive on <i>11-24, 1959</i> , and that death occurred at <i>No</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>No</i>		DATE SIGNED <i>No</i>	
ACTUAL SIGNATURE <i>W. E. Stone</i>	M.D. <i>Western Md.</i>		
PHYSICIAN'S NAME (Type) <i>W. E. Stone</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Finksburg Cemetery	22d. LOCATION (City, town, or county) (State) Finksburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons	ADDRESS Reisterstown, Md.	24a. REC'D BY REGISTRAR DATE DEC 1 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



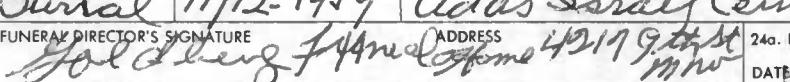
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12419

12432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 4 y. 8 mo. 3 d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) a. Baltimore City 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3625 Columbia Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cyrries	Middle Dorothy	Last Kellner
4. DATE OF DEATH	Month November	Day 10	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-08
9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Gainfully Emp.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emmanuel Kellner Deceased		14. MOTHER'S MAIDEN NAME Mollie Kellner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 230X DUE TO Neoplasm in the Intestines. INTERVAL BETWEEN ONSET AND DEATH 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Ulcerative Colitis. 5 years			
Chronic Brain Syndrome associated with Convulsive Seizures			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 7, 19 55</u> , to <u>November 10, 19 59</u> that I last saw the deceased alive on <u>November 10, 19 59</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE 		M.D. Sykesville, Maryland November 10, 1959	
PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.		Springfield State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12-1959	
22c. NAME OF CEMETERY OR CREMATORIUM Adas Israel Cemetery		22d. LOCATION (City, town, or county) Washington DC (State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur & Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PROGRESSIVE LEADERSHIP
FOR A NEW STAGGERED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12420

CERTIFICATE OF DEATH

Reg. Dist. No.

12433

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville		d. STREET ADDRESS Box 6, Batson Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Theodore	Last Kelly	4. DATE OF DEATH	Month 11	Day 27	Year 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1890		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Spencerville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nelson E. Kelly				14. MOTHER'S MAIDEN NAME Selena Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. Unknown		INFORMANT Eleanor Smith - Niece	Address Box 6, Batson Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident due to hypertensive 443X DUE TO cardiovascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Undiagnosed minimal pulmonary disease. (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on Nov. 27, 1959		Nov. 25, 1959, to Nov. 27, 1959		and that death occurred at 5:00A		from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Edgars M. Maculans</i>		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 11-27-59					
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt.		Henryton State Hospital, Henryton, Md.					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/59		22c. NAME OF CEMETERY OR CREMATORIAL Reed Oak Cem. - Spencerville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sander</i>		ADDRESS Rockville Rd.		24a. REC'D BY REGISTRAR C. Thomas		24b. REGISTRAR'S SIGNATURE C. Thomas	
VS A15 (4) 1SM 9/58		DATE NOV 30 '59					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 5yr. 2mo. 14da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 24		3. VOl-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2416 Fleet St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Benedict	Middle Thomas	Last Krug	4. DATE OF DEATH 11	Month 11	Day 12	Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-92	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ferryman		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Krug		14. MOTHER'S MAIDEN NAME Madelene Gast					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes	16. SOCIAL SECURITY NO. 1918	17. INFORMANT unknown	Address Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: Myocardial Infarction IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u> } (b) Generalized arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH Minutes more than 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental deficiency, undifferentiated.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State)
21. I certify that I attended the deceased from Aug. 1955, 19, to 11-12-1959, that I last saw the deceased alive on 11-12-59, 19, and that death occurred 7:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Walter Knopp, M.D.		Springfield State Hospital					
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 16, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer		22d. LOCATION (City, town, or county) Baltimore, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		ADDRESS		24a. REC'D BY REGISTRAR NOV 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12421

12434 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		d. STREET ADDRESS <i>78 Main St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles A. Kohls</i>		First	Middle	Last	4. DATE OF DEATH Month <i>November 10</i>	Day	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22 1887</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chimney</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Kohls</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Whittman</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>W.W. 1-11</i>		17. INFORMANT <i>me</i>		Address <i>Mrs Minnie Kohls - Sykesville, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>441X</i>		ARTERIOLAR NEPHROSCLEROSIS, MALIGNANT				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		HYPERTENSIVE CARDIOVASCULAR DISEASE				10 yrs.	
DUE TO (c)		ARTERIOSCLEROTIC HEART DISEASE				10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1949</i> , 19, to <i>Nov. 10</i> , 1959, that I last saw the deceased alive on <i>Nov. 9</i> , 1959, and that death occurred at <i>4:15 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wm. H. Lawson, Jr., M.D.</i>						ADDRESS (Street, city or town, state) <i>Liberty Road at Eldersburg</i>	
PHYSICIAN'S NAME (Type) <i>Wm. H. Lawson, Jr., M.D.</i>						DATE SIGNED <i>11/10/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-12-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Springfield</i>		22d. LOCATION (City, town, or county) (State) <i>Sykesville, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Height Sykesville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Height</i>	

STATE OF CALIFORNIA - DEPARTMENT OF PUBLIC SAFETY - CALIFORNIA STATE POLICE

CERTIFICATE OF DEATH

DEATH CERTIFICATE

Booker, California

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
12436 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster Rural</i>	c. LENGTH OF STAY IN 1b <i>40 yrs</i>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster Rural</i>	d. STREET ADDRESS <i></i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>CHARLES - A - MAHANNA</i>	4. DATE OF DEATH <i>Nov 18 1959</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 2-25-1895</i>	9. AGE (In years from birthday) <i>64 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles E Mahanna</i>	14. MOTHER'S MAIDEN NAME <i>Ella Ward</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT <i>Vernon Mahanna</i>	Address <i>Hampstead Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. L. Speicher</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <i>acting</i>	DATE SIGNED <i>Nov 18 1959</i>		
22a. BURIAL, Cremation, Removal (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-21-59</i>	22c. NAME OF CEMETERY OR CINERARY <i>Leister</i>	22d. LOCATION (City, town, or county) (State) <i>Carroll Co Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Gipton Hampstead Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>NOV 20 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Keane</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12424

12437

CERTIFICATE OF DEATH

Reg. Dist. No. 12424

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 22days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leon	Middle Joseph	Lost
4. DATE OF DEATH	Month November	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1909
9. AGE (In years last birthday) 49	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Leon Joseph McComas	14. MOTHER'S MAIDEN NAME Catherine Dewart		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-09-5359	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 455X			
DUE TO Acute peritonitis			
INTERVAL BETWEEN ONSET AND DEATH Days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Septicemia caused by infected gangrenous feet			
Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute brain syndrome associated with drug or poison intoxication.			
Steroid medication & periarteritis nodosa.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from October 27, 1958 , to November 19, 1959 , that I last saw the deceased alive on November 19, 1959 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 11/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11-24-59	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.	22d. LOCATION (City, town, or county) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd.	ADDRESS Leonard J. Ruck 5305 Harford Rd.	24a. REC'D BY REGISTRAR NOV 23 '59	24b. REGISTRAR'S SIGNATURE Orville S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12425

12438

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b RURAL and give nearest town Rural Taneytown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Luther First David Middle Mehring Last		4. DATE OF DEATH Month Day Year November 10, 1959	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 18, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther W. Mehring		14. MOTHER'S MAIDEN NAME Leah Reindollar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Dr. Percy Mehring, Phila., Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 6 hrs Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio Sclerosis ? (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 6, 1959 , to 11-10-1959 , that I last saw the deceased alive on 11-11-1959 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. N. Legg		ADDRESS (Street, city or town, state) Address: Belvoir Rd., Belvoir, Md. 20740	
PHYSICIAN'S NAME (Type) T. H. Legg		DATE SIGNED 11-12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery		22d. LOCATION (City, town, or county) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Merleyn C. Fuss		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
C.O. Fuss & Son Taneytown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

HEAD TO STATION

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12426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yr. 8 mo. 27 day.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 5318 Maple Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bessie		First	Middle	Last	4. DATE OF DEATH Melvin	Month November	Day 22,	Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, DIVORCED, WIDOWED WIDOWED	DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-12-81	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Hawes			14. MOTHER'S MAIDEN NAME Sarah Muse			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT		Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 2 weeks									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (decompensated) DUE TO Arteriosclerotic Heart Disease (decompensated) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Circulatory Disturbance, with Cerebral Arteriosclerosis, with Psychotic Reaction. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 6, 1955 , to November 22, 1959 , that I last saw the deceased alive on November 22, 1959 , and that death occurred at 9:25A M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) DATE SIGNED November 22, 1959									
ACTUAL SIGNATURE Joseph Flores M.D. M.D. _____									
PHYSICIAN'S NAME (Type) Joseph Flores, M.D.		Springfield State Hospital, Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Lickner & Sons - Balt		ADDRESS 17 Ma		24a. REC'D BY REGISTRAR NOV 24 '59		24b. REGISTRAR'S SIGNATURE Wm J. Lickner & Sons			

12440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. LENGTH OF STAY IN 1b 11 m. 27 d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Della		First Henrietta	Middle Miss.
4. DATE OF DEATH November 16, 1959		Month November	Day 16
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated
8. DATE OF BIRTH January 25, 1898		9. AGE (In years last birthday) 61	10. IF UNDER 1 YEAR Months 61
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS. Days 61	13. HOURS 0
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME George Whipp	
16. SOCIAL SECURITY NO. 219-20-0518		17. INFORMANT Springfield State Hospital Record	18. ADDRESS
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1	
		DUE TO Rupture of left ventricle myocardium Minutes	
		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Myocardial infarction	
		DUE TO (c) Coronary arteriosclerosis Years	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, catatonic type		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Organic psychosis?	
25. TIME OF INJURY Hour o. m. p. m. 19		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	27. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 28. (City or town) (County) (State)
29. I certify that I attended the deceased from November 19, 1958 , to November 16, 1959 , that I last saw the deceased alive on November 16, 1959 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Konstantin Weber, M.D. Oak Street		30. DATE SIGNED 11/16/59	
31. ACTUAL SIGNATURE Konstantin Weber, M.D.		32. PHYSICIAN'S NAME (Type) Sykesville, Maryland	
33. BURIAL, CREMATION, REMOVAL (Specify) Burial		34. DATE THEREOF 11-18-1959	35. NAME OF CEMETERY OR CREMATORIAL Rocky Springs Cemetery
36. LOCATION (City, town, or county) Frederick, Maryland		37. ADDRESS Frederick, Md.	
38. REC'D BY REGISTRAR NOV 18 '59		39. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 98 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Macie		First Macie	Middle Bernice
Last Moon		4. DATE OF DEATH November 13 1959	Month Day Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1932
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Okay Moon		14. MOTHER'S MAIDEN NAME Emma Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-28-6214	INFORMANT Macie B. Moon - Patient
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 7, 1959 to November 13, 1959 that I last saw the deceased alive on November 13, 1959 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edgars M. Maculans ACTUAL SIGNATURE M.D. Henryton, Maryland DATE SIGNED 11-13-59			
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-19-59	22b. DATE THEREOF 11-19-59	22c. NAME OF CEMETERY OR CREMATORIUM St. of Maryland Park	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Neale, Elkridge, Md.		ADDRESS Elkridge, Md.	24a. RECEIVED BY REGISTRAR NOV 23 59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	DATE

REASONABLE PRICE TO TRADE

base price

special

each \$2

postage

send to me direct

letterbox each postage

postage each

each \$2

RE 05 SEP 1985

postage each

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12442

CERTIFICATE OF DEATH

12429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 9mos. 24days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) HERMAN		d. STREET ADDRESS 6301 Clearspring Road	
4. DATE OF DEATH RUNGE	Month November	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 23, 1875
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Runge		14. MOTHER'S MAIDEN NAME Beatha (last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT --- Records, Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) DUE TO Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 25, 1957 , to November 19, 1959 , that I last saw the deceased alive on November 19, 1959 , and that death occurred at 2:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo.</i>		ADDRESS (Street, city or town, state) Springfield State Hospital 11-19-59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 23, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemt.
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR DATE NOV 24 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Flores
ADDRESS 3000 E. Baltimore Street			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

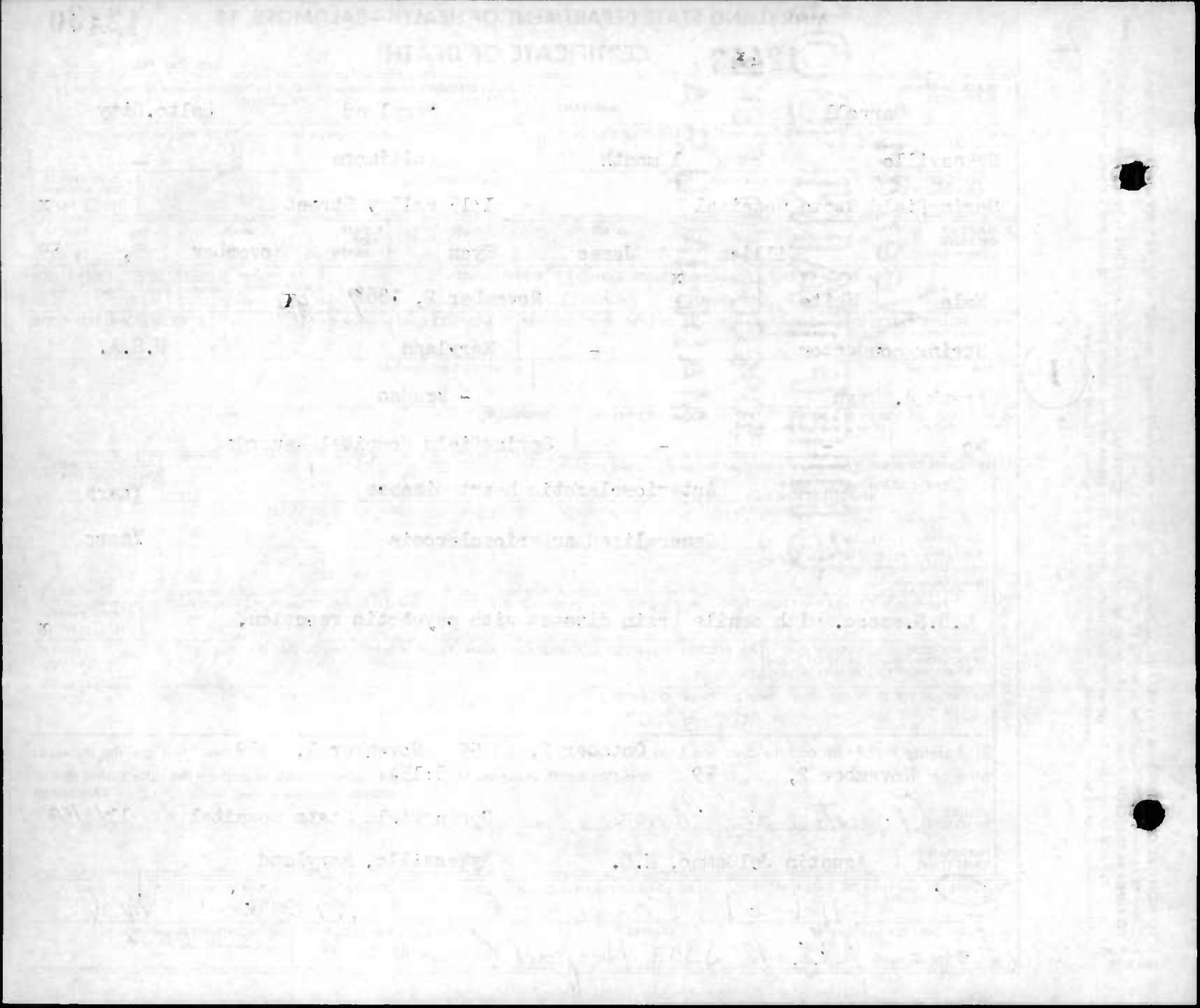
12430

12443

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 VQ1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1315 Valley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle James	Last Ryan	4. DATE OF DEATH November 2, 1867	Month November	Day 3, 1959	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1867	9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) String conductor		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Ryan		14. MOTHER'S MAIDEN NAME - Braden					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No - -		INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2, 1959, to November 3, 1959, that I last saw the deceased alive on November 2, 1959, and that death occurred at 5:15 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Agustin del Campo M.D. Springfield State Hospital 11/3/59 DATE SIGNED							
ACTUAL SIGNATURE Agustin del Campo		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-6-59		22b. DATE THEREOF 11-6-59		22c. NAME OF CEMETERY OR CEMATORIAL Parkwood		22d. LOCATION (City, town or county) Balto. City	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd		ADDRESS Leonard J. Ruck 5305 Harford Rd		24a. REC'D BY REGISTRAR DATE NOV 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Mann	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12444

CERTIFICATE OF DEATH

12431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mos. 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
3. NAME OF DECEASED (Type or print) Katherine		d. STREET ADDRESS 3803 Ednor Road	
3. NAME OF DECEASED (Type or print) Katherine		First O'Connor	Middle O'Connor
3. NAME OF DECEASED (Type or print) Katherine		Last Rytina	4. DATE OF DEATH November 12, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 24, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY - -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Roger O'Connor		14. MOTHER'S MAIDEN NAME Ann Flynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. - - -	INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Bronchopneumonia			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic cardiovascular disease			
(c) Generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 14, 1959 , to November 12, 1959 , that I last saw the deceased alive on November 11, 1959 , and that death occurred at 5:35 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 11/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/16/59	22c. NAME OF CEMETERY OR CREMATORIUM CATHEDRAL
22d. LOCATION (City, town, or county) FREDERICK RD MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. B. Bros</i>		ADDRESS 7110 BELAIR RD	24a. REC'D BY REGISTRAR DATE NOV 16 '59
			24b. REGISTRAR'S SIGNATURE <i>C. L. & T. H. B. Bros</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 20&21 Film 253 12-3-59 a.m.s

12432

2445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 5 mos. 17 das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Evelyn	Middle Blanche	4. DATE OF DEATH Lost Schreck Month November Day 24, Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11-28-22	9. AGE (In years last birthday) 36 yrs. IF UNDER 1YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		10b. KIND OF BUSINESS OR INDUSTRY —	
13. FATHER'S NAME Robert Schreck		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-3123	
17. INFORMANT		Address Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the trachea by a DUE TO piece of meat. INTERVAL BETWEEN ONSET AND DEATH 921.7 seconds			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Schizophrenic Reaction, Paranoid Type			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inspirated meat	
20c. TIME OF INJURY Month, Day, Year Hour 12:30 a.m. p.m. 11-24-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SS Hospital
20f. (City or town) Sykesville		(County) Carroll (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		DATE SIGNED 11-24-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/59	
22c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park		22d. LOCATION (City, town, or county) Parkville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 30 '59	
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Harris</i>	

STATEMENT OF EXPENSES
MAXINE C. GARDNER

Statement of expenses made during month of May, 1968

Airfare - Lodging - Meal - Other

Airfare - Lodging -

Airfare - Lodging -

Airfare - Lodging -

80.00

80.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12433

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 30 yrs. 8 mos. 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
515		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3V01-4	
d. STREET ADDRESS 1307 Clarkson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Schwarz	Middle First
4. DATE OF DEATH November 17, 1959		5. DATE OF BIRTH June 10, 1882	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 10, 1882	9. AGE (In years lost birthday) 77 yrs.
S. SEX Female		10. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leopold Schwarz		14. MOTHER'S MAIDEN NAME Carrie Schauman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bilateral bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure Weeks			
DUE TO (c) Arteriosclerotic heart disease Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? Epilepsy with mental deficiency YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11, 1958 , to Nov. 17, 1959 , that I last saw the deceased alive on November 17, 1959 , and that death occurred at 9:20A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francesco Magro</i>		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) Francesco Magro, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/59	
22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) Fredrick Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Krauser Funeral Home</i>		ADDRESS 1216 S Charles St.	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE NOV 23 '59			

DEPARTMENT OF HEALTH - ALABAMA
CERTIFICATE OF DEATH

DEATH CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

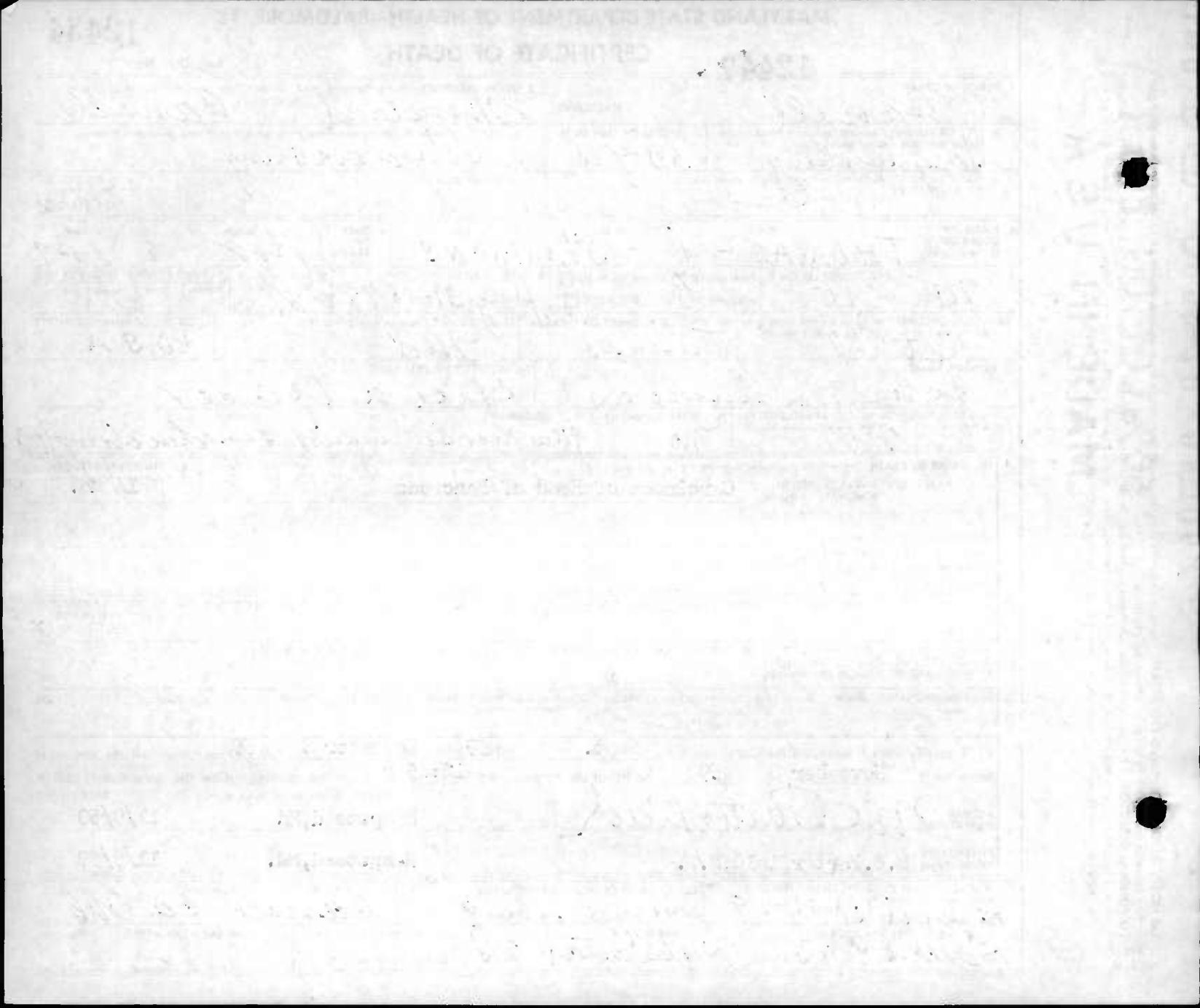
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12434

12447 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hayesburg</i>		c. LENGTH OF STAY IN 1b <i>52 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hayesburg</i>	
		d. STREET ADDRESS <i>—</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS - i - SIMMONS		First	Middle
		Lost	4. DATE OF DEATH <i>Nov 8</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 31-1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fanner</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
13. FATHER'S NAME <i>John N. Simmons</i>		14. MOTHER'S MAIDEN NAME <i>Alice a Spencer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	INFORMANT <i>Mrs. Thomas Simmons, Hayesburg Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 mo.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept.</i> , 19 <i>59</i> , to <i>November 8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>November 8</i> , 19 <i>59</i> , and that death occurred at <i>12:45 A</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i>	
ACTUAL SIGNATURE <i>M.C. Porterfield</i>		DATE SIGNED <i>11/9/59</i>	
PHYSICIAN'S NAME (Type) <i>M.C. Porterfield, M.D.</i>		Hampstead, Md. <i>11/9/59</i>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-11-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Hayesburg</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie Lupton</i>		ADDRESS <i>Hampstead Md</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 12 '59</i>
			24b. REGISTRAR'S SIGNATURE <i>Albert S. Evans</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

515

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 11, 12 Film G253 12-7-59 et
12448 CERTIFICATE OF DEATH

Reg. Dist. No. 12435

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11yr. 6mo. 21da.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Pool							
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 21 X - 2							
3. NAME OF DECEASED (Type or print)	First Ora	Middle	Last Sites						
4. DATE OF DEATH	Month November	Day 29	Year 1959						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28 1887						
9. AGE (In years last birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming Day Laborer	11. KIND OF BUSINESS OR INDUSTRY Agriculture	12. BIRTHPLACE (State or foreign country) Virginia						
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown							
16. SOCIAL SECURITY NO. Yoch.	INFORMANT SPRINGFIELD HOSPITAL RECORDS	Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 002 X PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senile psychosis, depressed phase.					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield	(County) (State)		
21. I certify that I attended the deceased from March 25, 1955 , to November 29, 1959 , that I last saw the deceased alive on November 29, 1959 , and that death occurred at 8:20 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11/29/59			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		M.D.		Sykesville, Maryland					
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-3-59	22c. NAME OF CEMETERY OR CREMATORIAL Bible Family Cemetery	22d. LOCATION (City, town, or county) Onego, W. Va.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE DEC 2 1959				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haight</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12449

Items 2, 11, 12 File # 253 12-7-59 et

12436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SPRINGFIELD HOSPITAL ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Sykesville, Md. ??		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHN	Middle -	Last SMITH	4. DATE OF DEATH 11 Day 28 Year 1959
S. SEX M	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER.		10b. KIND OF BUSINESS OR INDUSTRY WorK -		11. BIRTHPLACE (State or foreign country) UNKNOWN Maryland	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? UNKNOWN U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A RTERIOSCLEROTIC HEART DISEASE. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 FAR ADVANCED BILATERAL PULMONARY TUBERCULOSIS. ACTIVE. 2 SCHIZOPHRENIA 002 X					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT 1955 to 11-27 1959 that I last saw the deceased alive on 11-27 1959, and that death occurred at 7:25 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE JULIAN RADZYKIEWICZ		ADDRESS (Street, city or town, state) Sykesville, Md.		DATE SIGNED 11/28/59	
PHYSICIAN'S NAME (Type) JULIAN RADZYKIEWICZ MD		SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-59		22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral	
23. FUNERAL DIRECTOR'S SIGNATURE Julian Radzykiewicz		ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

WISCONSIN STATE BOARD OF HEALTH - DIVISION OF PUBLIC HEALTH
CERTIFICATE OF LABORATORY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12450

CERTIFICATE OF DEATH

Reg. Dist. No.

12437

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 18 yrs. 10 mos. 2 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Helen Jeanette Sowers		First Helen	Middle Jeanette	
4. DATE OF DEATH November 22, 1959	Month November	Day 22	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 9, 1892	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper	11. KIND OF BUSINESS OR INDUSTRY -	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Benjamin F. Sowers		14. MOTHER'S MAIDEN NAME Ida E. F. Bachtel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Springfield Hospital Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia				
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). Arteriosclerotic cardiovascular disease				
DUE TO (b) Arteriosclerotic cardiovascular disease Years.				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, hebephrenic type. Fracture, left tibia and fibula.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/7/55 , 19, to Nov. 22, 1959 , that I last saw the deceased alive on November 21, 1959 , and that death occurred at 6:20 A.M. from the causes and on the date stated above.				
ADDRESS (Street, city or town, state) ADDRESS DATE SIGNED 11/22/59				
ACTUAL SIGNATURE Agustini del Campo M.D. Springfield State Hospital				
PHYSICIAN'S NAME (Type) Agustini del Campo, M.D. Sykesville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORIUM 77-87 M. Anatomy Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Henel, Sykesville, Md.		24a. ADDRESS Frank J. Henel, Sykesville, Md.	24b. REC'D BY REGISTRAR NOV 27 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MAILED TO STANFORD LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12438

12451

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 3 V 01-4	
3. NAME OF DECEASED (Type or print) Nellie Pearce		d. STREET ADDRESS 1666 Northbourne Rd.	
4. DATE OF DEATH November 24, 1959		Month	Day
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY -	
10c. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Pearce		14. MOTHER'S MAIDEN NAME Mary Mossholder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-03-3102	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO <u>420.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>Years</u>			
(c) <u>Generalized arteriosclerosis</u> DUE TO <u>Years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1959</u> , to <u>November 24, 1959</u> , that I last saw the deceased alive on <u>November 24, 1959</u> , and that death occurred at <u>11:15 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Francesco Magro, M.D.</i>		M.D. Springfield State Hospital 11/24/59	
PHYSICIAN'S NAME (Type) Francesco Magro, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11'27'59	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE <i>Charles L. Krause</i>	

Montgomery, Alabama, 1914. It is now known as the Alabama State Penitentiary.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12439

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peterson Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amanda	First L.	Middle Stahley	4. DATE OF DEATH Month November Day 27 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1873
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 86 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joel Bollinger		14. MOTHER'S MAIDEN NAME Mary Bollinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	INFORMANT Mr. James P. Stahley	Address Taneytown, Md. RD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration. DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior deortic Heart Disease DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) Generalized Arteriosclerosis DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/11 , 19 44 , to 11/27 , 19 59 , that I last saw the deceased alive on 11/20 , 19 59 , and that death occurred at 5 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. S. McVaugh</i>	PHYSICIAN'S NAME (Type) <i>R. S. McVaugh</i>	ADDRESS (Street, city or town, state) <i>Taneytown, Md.</i>	DATE SIGNED <i>11/27/59</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 29, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Reformed Church in Taneytown	22d. LOCATION (City, town, or county) (State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merwyn C. Suss</i>	ADDRESS <i>Taneytown, Md.</i>	24a. REC'D BY REGISTRAR DATE DEC 1 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thane</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

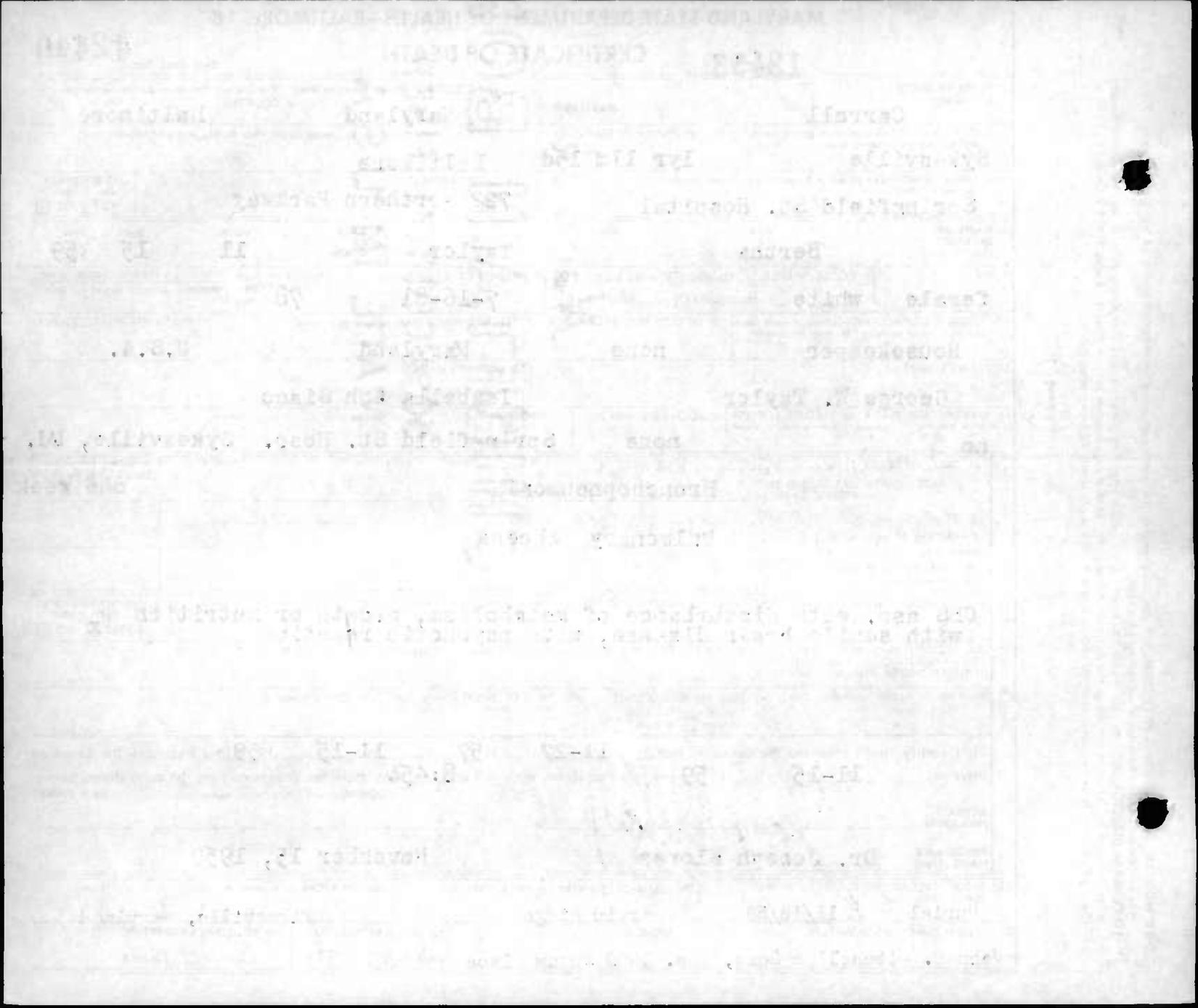
12453

CERTIFICATE OF DEATH

Reg. Dist. No.

12440

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb lyr 11m 15d	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield St. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Bertha		d. STREET ADDRESS 722 Northern Parkway	
4. DATE OF DEATH Last Taylor		Month 11	Day Year 15 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-16-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George W. Taylor		14. MOTHER'S MAIDEN NAME Isabella Ann Sisco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT none	
17. ADDRESS Springfield St. Hosp. Sykesville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Bronchopneumonia	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH one week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CBS ass. with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 11-15, 1959 , and that death occurred at 8:45A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Joseph Flores</i>		M.D.	
PHYSICIAN'S NAME (Type) Dr. Joseph Flores		November 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/59	
22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR NOV 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12454

CERTIFICATE OF DEATH

12441

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State hospital		d. STREET ADDRESS 15 x-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jackson	Middle	Last Thomas	4. DATE OF DEATH November 13 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-10-1916	9. AGE (In years less birthday) 43 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hemmington, Virginia	
13. FATHER'S NAME George E. Thomas		14. MOTHER'S MAIDEN NAME Mary Sayles		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	INFORMANT Jackson Thomas - Patient	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Sufficiency					
002X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver & Pulmonary tbc. with Pleurisy					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30, 1959 to November 13, 1959 , that I last saw the deceased alive on November 13, 1959 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Eduards M. Maculans					
ADDRESS (Street, city or town, state) Henryton, Maryland					
DATE SIGNED 11-13-59					
PHYSICIAN'S NAME (Type) Eduards M. Maculans, Supt.					
Henryton State Hospital, Henryton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/59	22c. NAME OF CEMETERY OR CREMATORIAL St. James Baptist		22d. LOCATION (City, town, or county) Bealeton, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowdon Rockville					
ADDRESS 1501 Rockville Rd					
24a. RECEIVED BY REGISTRAR NOV 18 '59					
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12442

Reg. Dist. No.

CERTIFICATE OF DEATH

12455

1. PLACE OF DEATH o. COUNTY Carroll County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY 31	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 year 6 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 5, Maryland		d. STREET ADDRESS 745 N. Patterson Pk. Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael	First	Middle	Last	4. DATE OF DEATH 11-22-59	Month	Day	Year 19
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-31-70		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dofs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A. Naturalized	
13. FATHER'S NAME George Trawinski		14. MOTHER'S MAIDEN NAME None given		INFORMANT Records		Address Springfield State Hosp. Sykesville, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-0807		17. PART I. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] IMMEDIATE CAUSE (a) 002 X DUE TO Far advanced bilateral pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerosis (c) Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 year 6 mo.	
18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome, associated with senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT OR UNDERLYING CAUSE (b) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-21-58 , 19____, to 11-22 , 19 59 , that I last saw the deceased alive on 11-21 , 19 59 , and that death occurred at 1:05a M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Chancie Magro</i> M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type) John Radzykewicz		XX Francesco Magro M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-24-1959	22c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary Cemetery	22d. LOCATION (City, town, or county) Springfield Hosp. Sykes, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Frank Czach & Son, 900 N. Chester St. Balto. 5		ADDRESS	24a. REC'D BY REGISTRAR NOV 23 '59	24b. REGISTRAR'S SIGNATURE <i>John Czach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG252 11-23-59 et

CERTIFICATE OF DEATH

12443

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3Y 10M 1D	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 5800 Walter Av., Baltimore 6, Md.	
3. NAME OF DECEASED (Type or print) u Emma Bertha Stuhm		First	Middle
		Last	Von Bussenius
4. DATE OF DEATH Nov. 14 1959		Month	Day
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3.13.80		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (State or foreign country) Germany
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	INFORMANT Springfield State Hospital
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Bronchopneumonia			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO Chronic Congestive Heart Failure (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome Associated with Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on 11-15-59, 19		1-13-56	to 11-14-59, 19, that I last saw the deceased 12.55 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE <i>Joseph Flores</i>		ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville, Md.	
PHYSICIAN'S NAME (Type) Joseph Flores		DATE SIGNED 11.11.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-1959	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Funeral Home</i>		ADDRESS 144 Belair Rd.	24a. REC'D BY REGISTRAR DATE NOV 17 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Sons</i>	

Name of deceased: JOHN D. COOPER

Name of attending physician

Age

Date of death

Year

Month

Day

Cause of death

Signature

Signature

Signature of State Health Officer

Signature

Signature of State Health Officer

Signature of State Health Officer

Signature of State Health Officer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12444

12457 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS E. Baltimore Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edna	Middle Jane	Last Wantz
4. DATE OF DEATH	Month November	Day 13	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1886
9. AGE (In years last birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own home	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Edward Carbaugh	14. MOTHER'S MAIDEN NAME Hannah Wantz	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none	INFORMANT Mr. Solomon E. Wantz, Taneytown, Maryland	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Coronary Occlusion sudden Terrorous Shock			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 7, 1958 , to Nov 8, 1959 , that I last saw the deceased alive on Nov 8, 1959 , and that death occurred at 7 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>T. H. Legg</i>		ADDRESS (Street, city or town, state) Union Bridge, Md. DATE SIGNED 11-15-59	
PHYSICIAN'S NAME (Type) T. H. Legg, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11/16/59 22c. NAME OF CEMETERY OR CREMATORIUM Baust Cemetery 22d. LOCATION (City, town, or county) (State) Tyrone, Carroll, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merlyn C. Fuss</i>		ADDRESS Taneytown, Maryland 24a. REC'D BY REGISTRAR Arthur S. Kraus DATE NOV 18 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

116-100

Analyst

Class 0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

CERTIFICATE OF DEATH

12445

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 368 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Y O 1 - 4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 610 Jasper Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Dorothy		First	Middle	Lost	4. DATE OF DEATH November	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 14, 1924	9. AGE (In years lost birthday) 35 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Waters				14. MOTHER'S MAIDEN NAME Ella Hughes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-10-1403		INFORMANT Dorothy Water - Patient		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitary pulmonary 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Tuberculosis, right thoracoplasty, right upper lobe resection (c) Cardiovascular Insufficiency								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from October 29, 1958, to November 1, 1959, that I last saw the deceased alive on November 1, 1959, and that death occurred at 5:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edgars M. Maculans, M.D.								
ADDRESS (Street, city or town, state) Henryton State Hospital DATE SIGNED 11-1-59								
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D.		Henryton, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/14/59		22b. DATE THEREOF 11/14/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn Cem.		22d. LOCATION (City, town, or county) BALTO., MD		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Bhalma		ADDRESS 1701 Mt. Bullish		24a. REC'D BY REGISTRAR DATE NOV 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

SECRET//NOFORN

REF ID: A6518

TO HOSPITAL may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12459

CERTIFICATE OF DEATH

Reg. Dist. No.

12446

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Carroll		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 25 yrs. 8 mos. 16 days	
Sykesville		Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Springfield State Hospital		3600 Fairview Ave. 3018 Nestwood N.Y.	
3. NAME OF DECEASED (Type or print)		First	Middle
		Mary	Theresa
4. DATE OF DEATH		Month	Day
		November	23, 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
		83 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Sewing plant; housework		-	Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frank J. Weber		Annie Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	INFORMANT
No		-	Springfield Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Days:	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Branchopneumonia	
422.1		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Congestive heart failure	
		Two weeks	
		(c) Arteriosclerotic cardiovascular disease	
		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Dementia praecox (schizophrenia)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955, to November 23, 1959, that I last saw the deceased alive on November 22, 1959, and that death occurred at 1:40 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Agustín del Campo</i>		DATE SIGNED 11/23/59	
PHYSICIAN'S NAME (Type)		M.D. Springfield State Hospital	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59	
22c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.		22d. LOCATION (City, town, or county) Pikesville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Libbertson</i>		ADDRESS 1130 Aves Balt.	
		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
		24b. REGISTRAR'S SIGNATURE <i>John S. Thane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12460

CERTIFICATE OF DEATH

12447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Woodbine		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural--Woodbine					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES		First	Middle	Last	4. DATE OF DEATH NOV. 12, 1959	Month	Day	Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1892	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired watchman		10b. KIND OF BUSINESS OR INDUSTRY Md. S.R.C.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Nimrod Welsh				14. MOTHER'S MAIDEN NAME Betty ??					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Martha M. Welsh, same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Thrombosis Gout Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 mth.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 2, 1959 to Nov 12, 1959, that I last saw the deceased alive on Nov 12, 1959, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE MORRELL N. MASTIN M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 12/1/59			
PHYSICIAN'S NAME (Type) MORRELL N. MASTIN									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-15-1959		22c. NAME OF CEMETERY OR CREMATORIUM Winfield Church of God		22d. LOCATION (City, town, or county) Carroll Co., Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE C. M. Waltz			

WILMINGTON STATE DEPARTMENT OF JUSTICE - SALEM

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 16 yrs. 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
515		03522	
3. NAME OF DECEASED (Type or print) Thomas		First F.	Middle White
4. DATE OF DEATH November 9, 1959		Month Day Year	Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1900
9. AGE (in years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Psychosis with syphilitic meningoencephalitis.</u> Fracture, left humerus.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) Md.
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED 11/10/59	
EXAMINED'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Nov. 10, 1959		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Newall</i>		ADDRESS Pleasanton 63-11	24a. REC'D BY REGISTRAR DATE NOV 13 '59
		24b. REGISTRAR'S SIGNATURE <i>Archie S. Keane</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12462

CERTIFICATE OF DEATH

Reg. Dist. No.

12449

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 5 mo. - 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2222 Washington Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ida	Middle Cohen	Last Witkowski
4. DATE OF DEATH	Month 11	Day 13	Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/93
9. AGE (In years last birthday) 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Max Cohen	14. MOTHER'S MAIDEN NAME Fanny Brodsky		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 288-05-7232	INFORMANT Springfield State Hosp.	Address Sykesville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 356.0			
DUE TO Bulbar Balsy			
INTERVAL BETWEEN ONSET AND DEATH years			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause lost.</u> (b) Arteriosclerotic Heart Disease			
years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CBS associated with senile brain disease??			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/25/59 , 19, to 11/13/59 , 19, that I last saw the deceased alive on 11/13/59 , 19, and that death occurred at 9:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francesco Magro</i>		ADDRESS (Street, city or town, state) Sykesville, Maryland	
PHYSICIAN'S NAME (Type) Francesco Magro, M.D.		DATE SIGNED 11/13/59	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF NOV. 15, 1959	22c. NAME OF CEMETERY OR CREMATORIAL KING DAVID MEM. GARDEN FALLS CHURCH	22d. LOCATION (City, town, or county) (State) VA.
23. FUNERAL DIRECTOR'S SIGNATURE B. DANIELSKY & SONS - 3501-14th & N.W.	ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

RCAG 173 34750

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1.
FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		12406		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Carroll		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Carroll	
Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		27		Westminster	
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
GARY		BRIAN	YINGLING	November 22	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 25 1959	1 yrs. 1 months 1 days 1 hours 1 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Hanover, Penna	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Arthur Yingling		Marie Stonesifer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mr. Arthur Yingling as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
692.1 Pneumonia					
DUE TO Cellulitis of Abdominal Wall.					
Conditions, if any, which gave rise to immediate cause (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11/25/59 22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley 22d. LOCATION (City, town, or country) (State) Pleasant Valley Md.					
23. FUNERAL DIRECTOR ADDRESS 24e. REC'D BY REGISTRAR NOV 24 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan					

